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ABSTRACT

Practitioners, researchers, and policy makers have attempted to improve the delivery of in-home service to the frail elderly through the expansion or merger of existing care providers or through the creation of coordinating units. To investigate the feasibility and effectiveness of a third approach to in-home services, 68 older adults (mean age,78 years) with maintenance health care or social needs participated over a 3-month period in the Integrated Continuing Care Program (ICCP), in Worcester, Massachusetts. The ICCP provided coordinated assessment, care plan, case management, homemaker-home health aide, and senior companion services to an experimental group of adults (N=33) through interagency cooperation, while a control group of adults (N=35) received services through a traditional, non-integrated approach. An analysis of the results showed no significant differences between the two groups in sociodemographic characteristics, number of impairments, problems in activities of daily living, amount of medication, emotional status, or length of stay in the program. The ICCP proved to be a viable model, both in units and costs of services provided. Those clients who were provided with integrated services used 13.0 hours of homemaker assistance and 13.9 hours of home health care per month, while the control group used 27.2 hours of homemaker help and 5.7 hours of home health care. The experimental clients averaged $291.37 per month for all indirect and direct services, a 12 percent saving; the control group clients averaged $325.89 per month. (BL)

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A MODEL FOR THE INTEGRATION OF COMMUNITY-BASED HEALTH AND SOCIAL SERVICES

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A MODEL FOR THE INTEGRATION OF COMMUNITY BASED HEALTH AND SOCIAL SERVICES

Introduction

For almost a decade, researchers, practitioners, and policy makers have been experimenting with ways to improve the delivery of in-home services to the frail elderly. Their goals have been to increase availability, accessibility and continuity of care: improve quality: contain cost, and ultimately to reduce the rate of institutionalization. Most of these early attempts involved the expansion or merger of existing care providers. A study of nine agencies by Reif[1] showed that although greater numbers of patients were served by the expanded or merged agencies and a larger volume of services were utilized, lack of reliable data made it impossible to determine whether quality had improved, institutional use had decreased, or unit costs had dropped. All nine agencies, according to Reif, encountered difficulties due to ineffective leadership, inadequate organizational structure, staff uncertainty about role and function, and poor financial management. The need to redefine the organization's purpose and function for the public, restrictions on funding for certain services and competition with more traditional entities were found to be additional problems facing the merged or expanded agencies.

Later demonstrations attacked the problem in a different way. With waivers from Medicare and Medicaid and grants from private foundations and public agencies, new coordinating units were created to carry out

[1]Laura Reif. "Expansion and Merger of Home Care Agencies: Optimizing Existing Resources Through Organizational Redesign." Home Care Services Quarterly, Volume 1, No. 3 Fall 1980, p. 14.

case assessments and to manage the delivery of services provided under contract by local agencies. The effectiveness of these models in achieving the goals cited earlier is not clear. While several of the individual projects succeeded in increasing services and coordination in their communities, their quality and cost studies were not conclusive. Some of the difficulty has been traced to the research methodology, particularly, the control groups and the assessment instruments, and to the limited time frame of the studies.[1] The National Long Term Care Demonstration Project (Channeling) currently underway is the latest endeavor. Much larger in scope and more costly than previous experiments, it may be successful in overcoming the problems which have troubled the earlier efforts.

The activities undertaken to expand agency service patterns or to create new ones are often viewed as a threat by existing community agencies. Seidl[2] and associates in their evaluation of the Wisconsin Community Care Organizations report that the effort by local providers to minimize the impact of the new Wisconsin projects on the local service system eventually resulted in the reshaping of the Organizations' goals. Creating a case management model for an existing service system may present other difficulties. It requires leadership that is able to respond to both the organizational and bureaucratic environment,

[1]Philip G. Weiler, "Evaluation of Alternatives in Long-Term Care," American Journal of Public Health, Vol. 73, No. 6, June 1983, p. 638-639.

[2]Frederick W. Seidl, Robert Applebaum, Carol Austin, and Kevin Mahoney, Delivering In-Home Services to the Aged and Disabled. Lexington: D.C. Heath and Co.) 1983, Chapter 5.

and, at the same time, to strike a balance between "voluntary and command-control coordination tactics"[1].

This report describes a third approach, the Integrated Continuing Care Program (ICCP), a hybrid of the single agency "merger" and the case management model, designed and developed as a cooperative program of the Elder Home Care Services of Worcester Area, Inc. (EHC) and the Visiting Nurse Association of Worcester (VNA). The purpose of the project was to create a more comprehensive assessment and management approach to the delivery of home care, using existing resources. It was funded by a Special Demonstration Grant (9 months) from the Massachusetts Department of Elder Affairs.

Elder Home Care Services is one of 27 "home care corporations" in the Commonwealth which contract with the Massachusetts Department of Elder Affairs to deliver social services to the elderly. In addition to case management, the agency provides information and referral services, senior companions, and arranges with local providers for homemakers, chore personnel, transportation, and home delivered meals. The VNA is certified for Medicare and Medicaid reimbursement and offers a full array of home health services.

Objectives and Methods

The ICCP was conceived as an experimental-control study in which eligible clients for EHC and VNA services would be randomly assigned to

[1]Dennis F. Beatrice, "Case Management: A Policy Option for Long-Term Care." in Reforming the Long-Term-Care System edited by James J. Callahan, Jr. and Stanely S. Wallack (Lexington: D.C. Heath and Co.) 1981, p. 141

either an experimental (treatment: integrated care) or control group. Potential study subjects would be persons 60 years or older, eligible for Medicaid, who were being transfered into the VNA's Continuing Care Unit from the Acute Area and who were also receiving EHC services. The VNA Continuing Care Unit is for patients who have reached maintenance level of care and for whom the future seems relatively stable. The Acute Area is the admission unit to the agency where patients receive intensive and intermediate level of care. A review of the agencies' intake data at the outset of the study suggested that over a four month period, there would be a large enough group of people meeting the above criteria to provide a sample of 100 cases for the study. These individuals would be divided alternately into an experimental and control group.

Integrated care refers to a system of service delivery which is based on a comprehensive assessment of the needs of the client and which involves one care plan, consolidated case management and joint monitoring. For the purpose of this study, it also included coordinated homemaker and home health aide care. Those experimental subjects needing both home health and homemaker services received a "combined" service worker who carried out both sets of tasks, rather than a homemaker through the EHC and a home health aide through the VNA. An Integrated Continuing Care Unit (ICCU) Team was responsible for the review of assessments, assignment of clients into the experimental and control groups, development of care plans, supervision of plan implementation, and monitoring of cases. It was comprised of the EHC Intake/Services Supervisor, the VNA Assistant Director of Clinical Services; the two VNA

Continuing Care Unit Supervisors; and the Project Coordinator. Policy and administrative decisions was handled by a Project Management Team composed of two senior staff members of EHC and VNA which met bi-monthly. Day-to-day operation was the responsibility of the part-time Project Coordinator.

The objectives of the Project were:

1. To establish an Integrated Continuing Care Unit for elderly clients of the EHC and VNA

2. To provide coordinated assessment, care plan, case management, homemaker-home health aide and senior companion services for 50 EHC-VNA clients (the Experimental Group)

3. To compare the units and cost of services received for the experimental Group with 50 EHC-VNA clients who are served in the traditional non-integrated manner for a three month period following intake (the control group).

In addition to evaluating the model in terms of units and costs of services, interviews were conducted with the Project Coordinator, Project Team members, supervisors, case managers, and homemakers-home health aides to assess the model's viability, quality of care and replicability.

Results

Experimental and Control Groups

When it became evident after the first few weeks of the study that the number of new referrals was less than had been expected, admissions were opened up to include Medicaid eligible patients in the VNA's Acute Area whose physical conditions were stable and whose health needs were, or would shortly be, maintenance oriented. Also, Medicaid clients already being served by the EHC and the VNA's Continuing Care Unit were

added to the pool of potential subjects. Because a few of the latter were reluctant to participate or to exchange their homemaker or home health aide for a "combined" worker, they were included in the control group. In spite of these attempts to build the sample, the total fell short of the goal. Seventy-eight persons, 39 Experimentals and 39 Controls were eventually included in the study, 10 of whom were terminated prior to completing the minimum length of stay of 60 days. (The initial three month minimum stay was reduced to 60 days because of the difficulty in obtaining the target number.) The final sample used for the analysis consisted of 33 experimentals and 35 controls. The two groups have been compared statistically for significant differences using the chi-square and t-test.

Length of Stay. The average length of stay in the Project for clients in the experimental group was 100.9 days (range: 60-172 days) and 106.7 for controls (range: 60-172 days). There was no statistical difference between the two groups in terms of length of stay.

Sociodemographic Characteristics. Approximately, three quarters of both groups were female: 79 percent of the experimentals and 74 percent of the controls. The ages of the clients in the experimental group ranged from 60 to 90 years and in the control group, from 60 to 84 years, with means of 77.84 years and 78.9 years respectively. Only a small percentage of either group (5 percent for experimentals and 11 percent for controls) were married. The remainder were single, widowed, divorced or separated. A majority of the clients lived alone: two

thirds of the experimental and over four-fifths of the control subjects. All persons in the experimental group were recipients of Social Security Income payments or eligible for EHC services. Among the control group, there were 5 individuals (15 percent) who were sliding fee clients of EHC. Again, there were no statistical differences in the two groups in terms of their sex, age, marital status, living arrangement and eligibility needs category. (Table 1)

Sources and Reasons for Referral. The most often cited referral sources for the experimental group were the home health agencies (39 percent), relatives (16 percent) and self-referral (16 percent). Other sources were social service agencies, mental health services, hospitals and nursing homes, but they accounted for relatively few of the clients. The control group clients were most apt to come from social service agencies (39 percent), home health agencies (17 percent) and self-referral (13 percent) with only a few from hospitals and nursing homes. This difference was statistically significant at the $p = .0046$ level. Health needs, accidents and hospital discharge accounted for approximately 30 percent of the referrals of both the experimental and control groups clients. Almost 50 percent of the experimental group needed homemaker service and 25 percent transportation, while 74 percent of the controls needed homemaker service and 15 percent, transportation. Other reasons cited were the existence of mental health problems and the need for companionship, supervision and mental health.

Table 1 Sociodemographic Characteristics of the Experimental and Control Groups

	Experimental Group n=33		Control Group n=35		Test for Statistical Difference
	#	%	#	%	
Sex					
Male	7	(21)	9	(26)	n.s.
Female	26	(79)	26	(74)	
Age (mean)	77.8		78.9		n.s.
Marital Status					n.s.
Single	4	(12)	6	(17)	
Married	5	(15)	4	(11)	
Widowed	23	(70)	20	(57)	
Divorced/Separated	1	(3)	5	(14)	
Living Arrangements*					n.s.
Spouse	5	(15)	2	(6)	
Children	5	(15)	3	(9)	
Other Relatives	4	(12)	2	(6)	
Alone	21	(64)	29	(83)	
Eligibility Needs Category					
SSI-OAA	24	(75)	22	(65)	
SSI-DA	4	(13)	3	(9)	
SSI-AB	2	(6)	3	(9)	
Income eligible	2	(6)	1	(3)	
Sliding Fee	-		5	(15)	
No Answer	1		1		

*total of percentage may exceed 100 percent because of more than one answer to question

Physical Health and Nutrition. The two groups, when compared statistically on physical health and nutrition showed no significant differences. A listing of the major impairments for each client indicated that the experimentals as a group averaged 3.73 in number compared to 3.86 for the controls. Among the experimental clients, 74 percent

Table 2 Sources and Reasons for Referral of Experimental and Control Group Clients

	Experimental Group n=33		Control Group n=35		Test for Statistical Difference
	#	%	#	%	
Source of Referral					p = .0046
Home Health Agency	12	(39)	4	(17)	
Hospital	1	(3)	2	(9)	
Social Service Agency	4	(13)	9	(39)	
Self Referral	5	(16)	3	(13)	
Nursing Home	1	(3)	2	(9)	
Mental Health Program	2	(6)	-		
Relative	5	(16)	-		
Other	1	(3)	3	(13)	
No Answer	2		12		
Reasons for Referral					
Health/Accident	5	(17)	7	(27)	
Discharge from Hospital	4	(13)	1	(4)	
Needed Transportation	8	(27)	4	(15)	
Needed Homemaker	14	(47)	20	(74)	
Needed Companion	1	(3)	1	(4)	
Needed Supervison	2	(7)	-		
Needed Mental Health Services	2	(7)	-		
Other	6	(20)	3	(11)	
No Answer	3		9		

*total may exceed 100 percent because of more than one answer to the question

required supportive devices for mobility compared to 81 percent for the control group members. The average number of medications used by the experimental subjects was 3.12; for the controls, it was 3.31. According to the case managers, most of the clients in the study managed their medications adequately (93 percent of the experimental group and 88 percent of the control) and seemed to be eating well (78 percent, experimentals; and 79 percent, controls). Less than a quarter of the clients

(22 percent, experimentals; 21 percent controls) had had a recent significant change in weight. However, a little more than half (56 percent) of the experimental clients and two thirds (66 percent) of the control clients were on special diets.

Activities of Daily Living. Similarly, the experimental and control subjects when compared statistically on activities of daily living showed no significant differences. A large majority of the experimental and control subjects were found to have difficulties with household management (88 percent, and 100 percent), meal time activities (85 and 91 percent), and transportation (82 and 74 percent)and a somewhat smaller proportion, with mobility and communication (61 and 66 percent). Financial problems were evident in 49 percent of the experimental cases and 69 percent of the controls while safety/security of personal property was troublesome to only 27 percent of the experimentals and 9 percent of the controls. (Table 3)

Social Support. According to the case managers, only 16 percent of the experimental group and 14 percent of the controls desired additional opportunities for socialization through community services, activities or companionship. The family was available to help all of experimentals and 86 percent of the controls, while friends and neighbors were available to almost half the clients. Little use was made of day care, friendly visitors, and homemakers-home health aides for this purpose (4 experimentals subjects and 5 control subjects). (Table 4)

Table 3 Activities of Daily Living Which Require Attention

	Experimental Group n=33		Control Group n=35		Test for Statistical Difference
	#	%	#	%	
Personal Care	18	(55)	21	(60)	ns
Mobility/Communication	20	(61)	23	(66)	ns
Mealtime Activities	28	(85)	32	(91)	ns
Safety/Security of Personal Property	9	(27)	3	(9)	ns
Management of Financial/Personal Affairs	16	(49)	24	(69)	ns
General Shopping	19	(58)	19	(54)	ns
Transportation	27	(82)	26	(74)	ns
Household Management	29	(88)	35	(100)	ns

Finally, the response to the question regarding the client's emotional state indicated that such a problem existed for only 9 percent of the experimentals and 11 percent of the controls. Again, there were no significant differences between the two groups when measured on these variables. (Table 5)

Units and Cost of Services

Despite the fact that the random allocation process for creating the experimental and control groups had been compromised early in the ICCP, there appeared to be no significant differences in the two groups as measured by the sociodemographic, physical health and nutrition, and social support variables. Therefore, for the purpose of this study, it

Table 4 Social Supports Available to Experimental and Control Groups

	Experimental Group n=33		Control Group n=35		Test for Statistical Difference
	#	%	#	%	
Desire for Additional Socialization Opportunities					ns
Yes	5	(16)	5	(14)	
No	27	(84)	30	(86)	
No Answer	1		-		
Other Social Supports used or available					ns
Family	33	(100)	31	(86)	
Friends/Neighbors	14	(42)	16	(46)	
Homemakers	4	(12)	4	(11)	
Day Care	3	(9)	2	(6)	
Friendly Visitor/ Companion	1	(3)	1	(3)	
Other			1	(3)	

Table 5 Emotional State of the Experimental and Control Groups

	Experimental Group n=33		Control Group n=35		Test for Statistical Difference
	#	%	#	%	
Does the client's emotional state appear to be a problem at this time?					n.s.
Yes	3	(9)	4	(11)	
No	29	(91)	31	(89)	
No Answer	1				

was assumed that the groups were from the same population and than any differences in the utilization of services resulted from the ICCP.

For each client in the study, both client indirect (e.g., assessment, caseplanning, travel to client, etc.) direct (e.g., homemaker, home health aide, nurses, etc.) service hours and costs were calculated. Table 6 shows the total number of hours spent by the VNA and EHC staff in client indirect services. The mean number of hours per client given by the VNA staff over the entire period of the Project was 2.2, which was twice the number (1.1) for those in the control group. Accounting for most of the difference was "documentation", 17 percent of time spent on experimentals but none for controls. The hours given by the EHC staff to indirect service tasks for the experimentals was also about twice the amount of time necessary for the control group, 8.4 hours compared to 4.5 hours (statistically significant, $p = .029$) but distribution of time among the tasks was about the same.

The units of direct services are presented in Table 7 as the hours per client per month. Of particular interest to the study is the experience with the combined homemaker-home health aide. The average monthly use of homemakers for the experimental group was 12.9 (8.4 + 4.5) hours compared to 27.2 hours for the controls while the average monthly use of home health aides for the experimentals was 13.9 (7.4 + 6.4) compared to 5.7 for the controls. Other services were used much less frequently. More hours of registered nursing care and senior companionship are listed for experimentals while the control group received more hours of licensed practical nursing, chore, transportation, day care, friendly visiting services and home delivered meals.

Table 6 Service Hours Provided to Experimental and Control Group Clients by Elder Home Care Services and Visiting Nurse Association

Services	Experimental Group n=33		Control Group n=35		Test for Statistical Difference
	#	%	#	%	
VNA Client Indirect Services					
Assessment	8.0	(11)	8.5	(23)	
Case Plan	4.0	(5)	1.5	(4)	
Client Travel	-		-		
Agency Contact	0.5	(1)	-		
Client Visit	1.5	(2)	-		
Client Telephone	2.5	(3)	1.5	(4)	
Documentation	12.0	(17)	-		
Correspondence	-		0.5	(1)	
Case Supervision/ Consultation	8.5	(11)	2.0	(5)	
Case Conference (not ICCP)	37.0	(51)	23.0	(62)	
Total	74.0		37.0		
Average	2.2		1.1		p = .058
EHC Client Indirect Services					
Assessment	17.5	(6)	11.0	(6)	
Case Plan	23.0	(8)	12.5	(7)	
Client Travel	21.5	(8)	10.0	(6)	
Agency Contact	20.0	(7)	7.5	(4)	
Client Visit	62.0	(24)	50.0	(29)	
Client Telephone	55.0	(20)	38.5	(22)	
Documentation	34.5	(11)	21.0	(12)	
Correspondence	12.0	(4)	4.0	(2)	
Case Supervision/ Consultation	28.5	(10)	14.0	(8)	
Conference (not ICCP)	2.5	(1)	4.0	(2)	
Total	276.5		172.5		
Average	8.4		4.9		p = .029

Table 7 Service Hours Per Client Per Month Provided to Experimental and Control Groups During Stay in the Integrated Continuing Care Unit

	Experimental Group n=33	Control Group n=35
VNA Direct Client Services		
RN	1.4	0.3
LPN	1.4	3.3
Home Health Aide	7.4	5.7
Homemaker-Home Health Aide		
Homemaker Tasks	8.4	
Personal Tasks	6.4	
Physical Therapist	0.1	
Occupational Therapist		<.01
Senior Compaion	2.5	1.5
EHC Client Direct Services		
Homemaker	4.5	27.2
Chore	0.2	0.3
Transportation	0.9	0.1
Home Delivered Meals	1.6	5.1
Other Services		
VNA/EHC Contact	0.2	0.1
Day Care		0.9
MD visits	0.1	<.01
Friendly Visitor	0.9	0.2
Companion		0.3
Other		

Using a schedule of rates supplied by the vendors and the VNA, the cost of services was calculated for the two groups. Table 8 gives the cost per client per month for the categories of services utilized. Included in the total are the cost assessed by the VNA for administration/management (figured separately for each client) and an average cost of $7.05 set by EHC for administration/management. The cost per experi-

mental client per month was $291.37 compared to $325.89 for the control client, a difference of $34.52 or 12 percent due primarily to the substitution of the "combined" homemaker-home health aide service for the separate paraprofessionals and the resulting reduction in service hours.

Table 8 Cost in Dollars for Client Indirect and Direct Services Utilized by the Experimental and Control Groups Per Client Per Month

	Experimental Group n=33	Control Group n=35
VNA Client Indirect Services	$ 9.13	$ 3.50
EHC Client Indirect Services	15.48	8.73
VNA Client Direct Services	160.72	70.13
VNA Administrative Cost	42.18	18.40
EHC Client Direct Services	40.11	199.16
Other Services	21.78	24.05
ICCP Administrative Cost	1.97	1.92
TOTAL	$291.37	$325.89

Model Viability

For the purpose of assessing the viability of the model, the staff was questioned about the organizational structure, decision making, supervision, communication and satisfaction. According to the interviewees, except for a few modifications in the program procedures, the ICCP did operate as designed. The Project Management Team functioned smoothly. As one member commented, "It was effective, dealt with opera-

tional issues and clarified problem areas." There was less unanimity among the staff concerning the ICCU Team. The EHC Intake/Services Supervisor who represented EHC on the Team found that her knowledge of individual cases was not adequate for the case planning although she spent as much time as she could prior to the meetings familiarizing herself with the cases. She had been appointed to the Team as the EHC staff person most equivalent in experience and training to the VNA Continuing Care supervisors. Because of the manner in which EHC is organized, the Project would have been better served had a staff person with more direct contact with clients (case managers) been appointed to the ICCU Team.

Responding to the question of decision making and control, the members of the ICCU Team said that decisions were made by consensus. If a disagreement arose, which occurred very rarely, the issue was discussed until a common solution was found. Usually, the EHC staff member deferred to the VNA on medical and health matters, while the reverse generally occurred for the psycho-social aspects of the case under question. Supervision was handled in the usual fashion, with the assigned case manager, nurse, and supervisors continuing to be involved in their cases. The selection of a lead agency did not seem to be a problem. If was made on the basis of which agency was responsible for delivering the bulk of the services. In general, the major participants in the ICCP were satisfied with the structure and functioning of the program. Most of them had been involved in the initial planning and were committed to the principle of integrated care.

On the other hand, there was a great deal of resentment on the part of the EHC case managers and their supervisors. They had not participated in the preliminary development stages of the Project and viewed the requests for referrals, assessments and documentation as an added burden. They didn't understand which agency was "leading" and who was reporting to whom. Contrary to what had been expected, communication did not increase between the EHC case manager and the VNA primary nurse. IT was pre-empted by the ICCU Team. They did not believe that the project had been researched sufficiently prior to implementation, nor did they believe that their orientation and instructions had been adequate. Apparently, a different managerial style existed within the VNA since these problems did not arise or at least they did not come to the attention of the Project Coordinator, Management Team, or evaluator.

Quality of Care

When asked about the effect of the ICCP on quality of care, most of the respondents replied that they thought it had been positive. Consideration of both the health and social service needs, they reported, resulted in a more comprehensive case assessment and plan. Having a nurse and social worker discuss plan and monitor the cases together added to their understanding of the particular situation, produced more ideas and allowed for fewer omissions. More referrals were made for psychiatric assessments, counseling, and socialization than had been the usual practice. Case managers voiced some reservations, however, about the lengthy consent form which was confusing to some clients, the delay in the initiation of services in some several instances, and the study

procedures which hampered the development of a relationship between the client and case manager.

Among the professional staff members who were interviewed, there was an overwhelming affirmative response to the homemaker-home health aide. For those clients with a "combined" worker, there was more continuity of care, less opportunity for problems to be left unresolved and more information on which to make judgements concerning the case. Almost all the clients liked the new arrangements. The persons performing the household-personal care tasks were more guarded in their opinion of the ICCP. Of the three aides interviewed, one was satisfied with her work, and felt happy with project and the way it had worked out for her. The second said that she was not too pleased with the arrangement especially since her clients did not want her to do the housework. The third stated that she did not like to do homemaking tasks all the time. She preferred her former schedule which allowed her to provide personal care to a larger number of clients for shorter periods of time.

Replicability

In responding to questions about the replicability of the Project, most interviewees stressed the need for adequate preparation of staff for successful implementation. It is essential, they said, that the staff understand the purpose of the ICCP, have some input into how they will be involved, and realize that some new procedures and functions may be necessary; acceptance depends on open communication between the various levels of personnel. These conditions did not always prevail at

EHC which may have been the reason why the case managers were less enthusiastic about the program than had been expected.

Finally, when asked to state the major strengths of the Project, the respondents answered:

- the commitment of the agencies to work together;
- the attitude of respect for each agency's role;
- the establishment of a framework for agency collaboration;
- the importance of health input for the EHC;
- the comprehensiveness of the assessment; and
- the utilization of a combined homemaker-home health aide,

Among the major weaknesses, the group said:

- the lack of involvement of the EHC line workers;
- the poor communication with the EHC case managers and supervisors;
- the extra work for the case managers and supervisors;
- the exclusion of some clients because did not meet eligibility criteria; and
- the time spent in documentation of hours and units of services.

Summary and Conclusions

The Integrated Continuing Care Program was a modest attempt by two agencies serving elderly persons in the community to work together to improve the quality of care and help reduce costs of their services. Compared to some of the much publicized long-term care experiments in the past decade that involved large outlays of funds and required the

establishment of new organizational units or the merger or expansion of existing ones, this demonstration involved relatively little expenditure and no major changes in organizational or community structure. It capitalized on the existence of good relationships between two agencies and their readiness to give up some autonomy over clients. The "heart" of the integrated program was the ICCU Team meetings during which members of both organizations reviewed the case assessments and care plans, noted and corrected gaps in information and services and monitored the clients' situation. As a special feature, the VNA created a new position for their agency, the "combined" homemaker-home health aide, who could carry out both homemaking and personal care. This service which was available in a few places in the Commonwealth, was new to the Worcester area.

Because of the very limited length of time for the study, units and costs of services were the only client factors chosen for outcome evaluation. To determine the effect of the program on these variables, an experimental methodology was selected with clients assigned to either an experimental or control group. Any observed differences, then, could be attributed to the impact of the "treatment," in this case, the integrated continuing care program. As with other attempts of this nature, it soon was obvious that the randomization procedure could not be adhered to in all instances. The less than anticipated number of referrals and client preferences made it necessary to include some persons only if they could be part of the control group. However, when the two groups (33 experimental clients and 35 control clients) were compared on a variety of factors including sociodemographic characteristics, number of impairments, problems in activities in daily living, number of medications, emotional

status, and length of stay in the program, there were no significant differences. Because of the similarity, comparisons were made in the units and costs of services received. Those clients who were provided with integrated services used 13.0 hours of homemaker assistance and 13.9 hours of home health care per month while the control group had 27.2 hours of homemaker help and 5.7 hours of home health aid. Monthly utilization rates of the other services were relatively low and varied as to which group was the higher user. The experimental group received more service from the nurses and senior companions. The control group used more licensed practical nurse assistance, chore service, transportation, home delivered meals, day care, and friendly visitor service. In terms of cost, the experimental clients averaged $291.37 per month for all ECH and VNA client indirect and direct services and the controls, $325.89, which represents a 12 percent saving.

The experience with the ICCP over the nine month period indicated that it was a viable model, but some modification appeared warranted. Both the Project Management Team and the Clinical Team functioned as planned. Decision making did not present any difficulty, nor did the problem of which agency was to control the case. Turf issues did not surface. Staffing and supervision could easily be accommodated within the existing managerial framework with relatively little disruption in day-to-day practice.

The Elder Home Care management staff believed that what they were doing was worthwhile and that the program was workable (with some modifications), and more beneficial to the clients. They acknowledged the problem they had in communicating with the various levels of staff and

tried to do something about it, although it was too late to help the study. The EHC case managers and supervisors spoke approvingly of the general goals of the ICCP, noting the importance of having the social and medical service providers work together and the effectiveness of the combined homemaker-home health aide. However, they complained about some specific tasks related to the demonstration: keeping track of experimental and control clients, finding eligible subjects, documenting hours and services, and responding to the changes in eligibility criteria. They also noted the lack of direct communication with the nurses and the impression that the nurses viewed them as paraprofessionals. For the VNA staff, the ICCP increased the flow of information and helped them to see the "overall picture" of their clients. But they also found the paper work and arrangements very time consuming.

These negative aspects did not dampen the enthusiasm of the two agencies. They have already organized a Task Force to begin to put some of the components of the ICCP into operation. To avoid one of the major problems of the demonstration project, they have included several case managers in the planning process. Initial case assessments and care plans will be the responsibility of a case manager-nurse team who will maintain communication either by telephone or arranged meetings. Orientation and training sessions are being scheduled for case managers and nurses so that each has a better understanding of the other's role and function. For the present, there are no plans to expand the combined homemaker-home health aide service until a more complete study can be made of the position, recruitment, and funding.

The ICCP accomplished its objectives with one exception. A smaller group of clients was involved than had been proposed as a result of a mistake by EHC in calculating the monthly admissions of Medicaid eligible clients. Not only was there a consensus among the participants that the ICCP provided better care than the traditional approach, there was also evidence that it did so more economically. The most serious shortcoming of the ICCP was the lack of involvement of the EHC case managers and the VNA nurses in the design and implementation of the project, a situation which was recognized partway through the experiment and which led to modifications in the guidelines currently being put into practice. In spite of the limitations of the scale and time frame of the project, the results suggest that the model can be effective in integrating health and social services. Because the ICCP does not require the merger or expansion of existing agencies nor the establishment of new ones, it may be a more attractive option for local communities than some of the earlier demonstrations.